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SENATE BILL 1884 By
Norris

HOUSE BILL 1881
By Todd

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, relative to health care coverage.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding Sections 2 through 17 of this act as a new part.

SECTION 2.

(a) The legislature finds that medically uninsurable Tennesseans face critical problems with respect to health care coverage, access to care, job mobility, and family impoverishment arising from their health status.

(b) Competitive forces in the marketplaces for health care and health insurance will operate over time to increase the number of medically uninsurable persons.

(c) To provide for access to quality health care at minimum cost to the public, to relieve the insurable population of the disruptive cost of sharing coverage, and to maximize reliance on strategies of managed care proven by the private sector, the legislature hereby authorizes the Tennessee Health Insurance Risk Pool.

(d) The creation of the Tennessee Health Insurance Risk Pool is not intended to diminish the availability of traditional health care insurance to consumers who currently are eligible for these policies.

SECTION 3. As used in this act, unless the context otherwise requires:

(1) "Benefits plan" means coverage to be offered by the pool to eligible persons under Section 12 of this act.

(2) "Board" means the board of directors of the pool.

(3) "Commissioner" means the commissioner of commerce and insurance.

(4) "Department" means the Tennessee department of commerce and insurance.

(5) "Dependent" means a resident spouse or unmarried child younger than twenty-five (25) years of age, a child who is a full-time student younger than twenty-five (25) years of age and who is financially dependent upon the parent, a child who is eighteen (18) years of age or older and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

(6) "Family member" means a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

(7) "Health insurance" means individual or group health insurance and includes any hospital and medical expense incurred policy, a fraternal benefit society, a stipulated premium company, an approved nonprofit health corporation, health maintenance organization subscriber contract, coverage by a hospital and medical service plan, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. The term does not include short-term, accident, dental-only, vision-only, fixed indemnity, including hospital indemnity insurance, credit insurance, long-term care, disability income, or other limited benefit insurance, including specified disease insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable

with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(8) "Health maintenance organization" means a health maintenance organization that has a certificate of authority to operate in this state under Tennessee Code Annotated, title 56, chapter 32, part 2.

(9) "Hospital" means a licensed public or private institution as defined by § 68-11-201(23), and any hospital owned or operated by the federal or state government.

(10) "Insured" means a person who is a resident of this state and a citizen of the United States and who is eligible to receive benefits from the pool. The term "insured" may include dependents and family members.

(11) "Insurer" means any entity that provides health insurance in this state, including stop-loss or excess loss insurance. For the purposes of this act, "insurer" includes but is not limited to an insurance company; a health maintenance organization; an approved nonprofit health corporation; a fraternal benefit society; a stipulated premium insurance company; a hospital and medical service corporation; a surplus lines carrier; an insurer providing stop-loss or excess loss insurance to physicians, health care providers, hospitals, or to any benefit arrangements to the extent permitted by Section 4, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(12) "Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers, employees, or other personnel but does not include health care services covered through an insurer.

(13) "Medicare" means coverage provided by Part A and Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.).

(14) "Physician" means a person licensed to practice medicine in this state under Tennessee Code Annotated, title 62, chapter 6 or 9.

(15) "Plan of operation" means the plan of operation of the pool and includes the articles, bylaws, and operating rules of the pool that are adopted by the board under Section 6 of this act.

(16) "Pool" means the Tennessee Health Insurance Risk Pool.

(17) "Resident" means:

(A) An individual who has been legally domiciled in Tennessee for a minimum of thirty (30) days for persons eligible for enrollment in the pool under Section 11(b) of this act; or

(B) An individual who is legally domiciled in Tennessee for persons eligible for enrollment in the pool under Section 11(a) of this act.

SECTION 4. The Tennessee Health Insurance Risk Pool is created.

SECTION 5.

(a) The pool is governed by a board of directors composed of nine (9) members.

(b) The commissioner shall appoint members of the board for staggered six-6-year terms as provided by this section.

(c) The board shall be composed of:

(1) At least two (2) persons affiliated with an insurer admitted and authorized to write health insurance in this state, but no more than four (4) such persons;

(2) At least two (2) persons who are insureds or parents of insureds or who are reasonably expected to qualify for coverage by the pool;

(3) The remaining members of the board may be selected from individuals such as a physician licensed to practice in this state by the

Tennessee state board of medical examiners, a hospital administrator, an advanced nurse practitioner, or representatives of the general public who are not employed by or affiliated with an insurance company or plan, hospital and medical service corporation, or health maintenance organization or licensed as or employed by or affiliated with a physician, hospital, or other health care provider. A representative of the general public does include a person whose only affiliation with an insurance company or plan, hospital and medical service corporation, or health maintenance organization is as an insured or person who has coverage through a plan provided by the corporation or organization.

(d) If a vacancy occurs on the board, the commissioner shall fill the vacancy for the unexpired term with a person who has the appropriate qualifications to fill that position on the board.

(e) Each member of the board is entitled to be paid a per diem for each day on which the member performs his duties as a member of the board and to reimbursement of his expenses while engaged in performing his duties as a member of the board. The amount of per diem and the amount of reimbursement for expenses is the same as provided for members of the general assembly.

(f) The commissioner shall designate one (1) of the commissioner's appointees to the board to serve as chairman. The chairman serves in that capacity at the pleasure of the commissioner.

(g) A member of the board of directors is not liable for an action or omission performed in good faith in the performance of powers and duties under this act, and cause of action does not arise against a member for the action or omission.

SECTION 6.

(a) The pool's initial board shall submit to the commissioner a plan of operation for the pool that will assure the fair, reasonable, and equitable administration of the pool.

(b) In addition to the other requirements of this act, the plan of operation must include procedures for:

(1) Operation of the pool;

(2) Selecting an administrator as provided under Section 8 of this act;

(3) Creating a fund, under management of the board, for administrative expenses;

(4) Handling, accounting, and auditing of money and other assets of the pool;

(5) Developing and implementing a program to publicize the existence of the pool, the eligibility requirements for coverage under the pool, enrollment procedures, and to foster public awareness of the plan;

(6) Creation of a grievance committee to review complaints presented by applicants for coverage from the pool and insureds who receive coverage from the pool; and

(7) Other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this act.

(c) After notice and hearing, the commissioner shall approve the plan of operation if it is determined that the plan is suitable to assure the fair, reasonable, and equitable administration of the pool.

(d) The plan of operation takes effect on the date it is approved by commissioner order.

(e) If the initial board fails to submit a suitable plan of operation before the 180th day following the appointment of the initial board, the commissioner, after notice and hearing, may adopt all necessary and reasonable rules to provide a plan for the pool. The rules adopted under this subsection shall continue in effect until the initial board submits, and the commissioner approves, a plan of operation under this section.

(f) The board shall amend the plan of operation as necessary to carry out this act. Amendments to the plan of operation must be approved by the commissioner before they become part of the plan.

SECTION 7.

(a) The pool may exercise any of the authority that an insurance company authorized to write health insurance in this state may exercise under the law of this state.

(b) As part of its authority, the pool may:

(1) Provide health benefits coverage to persons who are eligible for that coverage under this act;

(2) Enter into contracts that are necessary to carry out this act including, with the approval of the commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions;

(3) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool;

(4) Institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amounts paid by the pool as a mistake of fact or law, and to recover other amounts due the pool;

(5) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, and claim reserve formulas and perform any actuarial functions appropriate to the operation of the pool;

(6) Adopt policy forms, endorsements, and riders and applications for coverage;

(7) Issue insurance policies subject to this act and the plan of operation;

(8) Appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool;

(9) Employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions;

(10) Contract for stop-loss insurance for risks incurred by the pool;

(11) Recover or collect assessments imposed under Section 14 of this act;

(12) Borrow money as necessary to implement the purposes of the pool;

(13) Issue additional types of health insurance policies to provide optional coverages which comply with applicable provisions of state and federal law, including Medicare supplemental health insurance;

(14) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review subject to Tennessee Code Annotated, title 56, chapter 6, part 7, and individual case management for the purpose of making the benefit plans more cost effective;

(15) Design, utilize, contract, or otherwise arrange for the delivery of cost- effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations; and

(16) Provide for reinsurance on either a facultative or treaty basis or both.

(c) The board shall promulgate a list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate.

(d) Not later than June 1 of each year, the board shall make an annual report to the governor, the speaker of the senate, the speaker of the house of representatives, and the commissioner. The report shall summarize the activities of the pool in the preceding calendar year, including information regarding net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

SECTION 8.

(a) After completing a competitive bidding process as provided by the plan of operation, the board may select one (1) or more insurers or a third party administrator certified by the department to administer the pool.

(b) The board shall establish criteria for evaluating the bids submitted. The criteria must include:

(1) An insurer's or third party administrator's proven ability to handle individual accident and health insurance;

(2) The efficiency of an insurer's or third party administrator's claims paying procedures;

(3) An estimate of total charges for administering the pool;

(4) An insurer's or third party administrator's ability to administer the pool in a cost-efficient manner; and

(5) The financial condition and stability of the insurer or third party administrator.

(c) An insurer or third party administrator selected as an administering insurer or third party administrator to administer the pool under this section shall serve for a term of three (3) years from the date on which the board issues its order formally making the selection.

(d) Not later than one (1) year before the expiration of an administering insurer's or third party administrator's term, the board shall invite all insurers, including the

administering insurer or third party administrator, to submit bids to serve for the succeeding three-year administration period. Selection of the succeeding administering insurer or third party administrator must be made not later than the sixth calendar month preceding the month in which the administering insurer's or third party administrator's term expires.

(e) The administering insurer or third party administrator shall perform such functions relating to the pool as may be assigned to it, including:

(1) Perform eligibility and administrative claims payment functions for the pool;

(2) Establish a billing procedure for collection of premiums from persons insured by the pool;

(3) Perform functions necessary to assure timely payment of benefits to persons covered under the pool, including:

(A) Providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

(B) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board relating to the operation of the pool; and

(5) Determine after the close of each calendar year the net written and earned premiums, expense of administration, and paid and incurred losses of the pool for that calendar year and report this information to the board and the commissioner on forms prescribed by the commissioner.

(f) The pool shall pay an administering insurer or third party administrator for its expenses incurred in performing its duties and functions as provided by the plan of

operation. Except as otherwise provided by this subsection, the total amount of administrative costs and fees paid in a calendar year to all administering insurers or a third party administrator may not exceed twelve and one-half (12.5) percent of the gross premium receipts of the pool for the calendar year. The commissioner may approve payment of a higher amount, not to exceed fifteen (15) percent of the gross premium receipts of the pool for the calendar year, if the commissioner determines that the higher amount is necessary to pay the administrative costs and fees of the pool.

(g) The board shall determine the form and content of the report required by subsection (e)(4) of this section and the time at which reports must be made.

(h) The board shall determine the times at which billing for the pool will be done by the administering insurer or third party administrator.

SECTION 9. The commissioner may by rule establish additional powers and duties of the board and may adopt other rules as are necessary and proper to implement this act. The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments made and collected under Section 15. Such rules shall be promulgated in accordance with the uniform administrative procedures act, compiled in title 4, chapter 5.

SECTION 10.

(a) Rates charged by the pool may not be unreasonable in relation to the coverage provided and the risk experience and expenses of providing the coverage.

(b) Rates and rate schedules may be adjusted for appropriate risk factors including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(c) Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex, and geographic location may apply for individual risks.

(d) The pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial pool rates may not be less than one hundred twenty-five percent (125%) and may not exceed one hundred fifty percent (150 %) of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall pool rates exceed two hundred percent (200%) of rates applicable to individual standard risks.

(e) All rates and rate schedules shall be submitted to the commissioner for approval, and the commissioner must approve the rates and rate schedules of the pool before they are used by the pool. The commissioner in evaluating the rates and rate schedules of the pool shall consider the factors provided by this section.

SECTION 11.

(a) An individual who is a resident, as defined by Section 3(17)(B) of this act, and who continues to be a resident, is eligible for coverage from the pool if the individual:

(1) Provides to the pool evidence that the individual has maintained health insurance coverage for the previous eighteen (18) months, with no gap in coverage greater than sixty-three (63) days, of which the most recent coverage was through an employer-sponsored plan, church plan, or government plan; or

(2) Provides to the pool evidence that the individual had health insurance coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the sixty-third (63rd) day after the date that coverage was terminated.

(b) Any individual who is and continues to be a resident, as defined by Section 3(17)(A) of this act, and who is a citizen of the United States or has been a permanent resident of the United States for at least three (3) continuous years is eligible for coverage from the pool if the individual provides to the pool:

(1) A notice of rejection or refusal to issue substantially similar individual insurance for health reasons by one (1) insurer, other than a rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage;

(2) A certification from an agent or salaried representative of an insurer, on a form developed by the board and approved by the commissioner, that states that the agent or salaried representative is unable to obtain substantially similar individual insurance for the individual with any state-licensed insurer that the agent or salaried representative represents because the individual will be declined for coverage as a result of a medical condition of the individual under the underwriting guidelines of the insurer;

(3) An offer to issue substantially similar individual insurance only with conditional riders;

(4) A refusal by an insurer to issue substantially similar individual insurance except at a rate exceeding the pool rate; or

(5) Diagnosis of the individual with one of the medical or health conditions listed by the board under Section 7(c) of this act and for which a person shall be eligible for pool coverage.

(c) Each dependent of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool. In the instance of a child who is the primary insured, resident family members shall also be eligible for coverage.

(d) A person may maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy.

(e) A person is not eligible for coverage from the pool if the person:

(1) Has in effect on the date pool coverage takes effect health insurance coverage from an insurer or insurance arrangement;

(2) Is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation, except:

(A) Coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person is satisfying any pre-existing condition waiting period under a pool policy; or

(B) Employer group coverage conditioned by the type of limitations described by subsections (b)(1) or (3) of this section; or

(C) Individual coverage conditioned by the limitations described by subsections (b)(3) or (4) of this section;

(3) Has terminated coverage in the pool within twelve (12) months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

(4) Is confined in a county jail or imprisoned in a state prison;

(5) Has premiums that are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider;

(6) Has had prior coverage with the pool terminated during the twelve (12) months immediately preceding the date of application for nonpayment of premiums; or

(7) Has had prior coverage with the pool terminated for fraud.

(f) Pool coverage shall cease:

(1) On the date a person is no longer a resident of this state, except for a child who is a student under the age of twenty-five (25) years and who is financially dependent upon the parent, a child for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent;

(2) On the date a person requests coverage to end;

(3) Upon the death of the covered person;

(4) On the date state law requires cancellation of the policy;

(5) At the option of the pool, thirty (30) days after the pool sends to the person any inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply;

(6) On the thirty-first (31st) day after the day on which a premium payment for pool coverage becomes due if the payment is not made before that date; or

(7) At such time as the person ceases to meet the eligibility requirements of this section.

(g) Coverage of a person who ceases to meet the eligibility requirements of this section shall be terminated on the earlier of the premium due date that follows the date the pool determines the person does not meet the eligibility requirements or the first day of the month that follows the month in which the pool determines the person does not meet the eligibility requirements. The pool has the sole discretion to determine that a person does not meet the eligibility requirements.

(h) A person who is eligible for health insurance benefits provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined, is not eligible for pool coverage. An insurer, agent, third party administrator, or other person licensed by the state may not arrange or assist in or attempt to arrange or assist in the application for pool coverage by, or placement in the pool of a person who is ineligible under this subsection for the purpose of separating the person from health insurance benefits offered or provided in connection with employment that would be available to the person as an employee or dependent of an employee. A violation of this section is an unfair method of competition and an unfair or deceptive act or practice under § 56-8-104.

SECTION 12.

(a) The pool shall offer pool coverage consistent with major medical expense coverage to each eligible person who is not eligible for Medicare. The board, with the approval of the commissioner, shall establish:

(1) The coverages to be provided by the pool;

(2) The applicable schedules of benefits; and

(3) Any exclusions to coverage and other limitations.

(b) The benefits provisions of the pool's health benefits coverages must include the following:

(1) All required or applicable definitions;

(2) A list of any exclusions or limitations to coverage;

(3) A description of covered services required under the pool; and

(4) The deductibles, coinsurance options, and copayment options that are required or permitted under the pool.

(c) The board may adjust deductibles, the amounts of stop-loss coverage, and the time periods governing preexisting conditions under Section 13 of this act to preserve the financial integrity of the pool. If the board makes such an adjustment it shall report in writing that adjustment together with its reasons for the adjustment to the commissioner. The report must be submitted not later than the thirtieth (30^{th}) day after the date the adjustment is made.

(d) Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile insurance whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(e) The pool has a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the pool may be reduced or refused as an offset against any amount recoverable under this subsection.

SECTION 13.

(a) Except as provided by this section and Section 12(c) of this act, pool coverage shall exclude charges or expenses incurred during the first twelve (12) months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) A preexisting condition provision shall not apply to an individual who was continuously covered for an aggregate period of twelve (12) months by health insurance that was in effect up to a date not more than sixty-three (63) days before the effective date of coverage under the pool, excluding any waiting period, provided that the application for pool coverage is made no later than sixty-three (63) days following the termination of coverage.

(c) In determining whether a preexisting condition provision applies to an individual covered by the pool, the pool shall credit the time the individual was previously covered under health insurance if the previous coverage was in effect at any time during the twelve (12) months preceding the effective date of coverage under the pool. Any waiting period that applied before that coverage became effective also shall be credited against the preexisting condition provision period.

SECTION 14.

(a) The board may assess insurers and make advance interim assessments as reasonable and necessary for the plan's organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year.

(b) If assessments exceed the pool's actual losses and administrative expenses, the excess shall be held in an interest-bearing account and used by the board to offset future losses or to reduce future assessments. As used in this section, future losses includes reserves for incurred but not reported claims.

(c) After the end of each fiscal year, the board shall determine and report to the commissioner the net loss, if any, of the pool for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. Any net loss for the year shall be recouped by assessments on insurers. Each insurer's assessment shall be determined

annually by the board based on annual statements and other reports required by the board and filed with the board.

(d) The assessment imposed against each insurer shall be in an amount that is equal to the ratio of the gross premiums collected by the insurer for health insurance in this state during the preceding calendar year, except for Medicare supplement premiums and small employer group health premiums subject to Tennessee Code Annotated, title 56, chapter 7, part 22. An assessment is due on a date specified by the board that may not be earlier than the thirtieth (30th) day after the date on which prior written notice of the assessment due is transmitted to the insurer. Interest accrues on the unpaid amount at a rate equal to the prime lending rate, as stated in the most recent issue of the Wall Street Journal, plus three percent (3%), determined as of the date such assessment is delinquent.

(e) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. If all or part of an assessment against an insurer is abated or deferred, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for computing assessments under this section. An insurer receiving an abatement or deferment under this subsection remains liable to the pool for the deficiency.

SECTION 15. An applicant or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board. The grievance committee shall report to the board after completion of the review of each complaint. The board shall retain all written complaints regarding the pool at least until the third anniversary of the date the pool received the complaint.

SECTION 16.

(a) The comptroller of the treasury shall conduct annually a special audit of the pool. The comptroller's report shall include a financial audit and an economy and efficiency audit.

(b) The comptroller shall report the cost of each audit conducted under this act to the board, and the board shall remit that amount to the comptroller for deposit to the general revenue fund.

SECTION 17.

(a) An insurer may provide a notification to its insureds regarding the creation of the Tennessee Health Insurance Risk Pool and the address for information on cost, coverage, eligibility, and other information where an insured can compare his or her current health insurance with the benefits plan offered by the pool. The insurer shall not incur any liability solely for providing such notification.

(b) An insurer providing notice under subsection (a) shall provide such notice as prescribed by the commissioner. The commissioner may promulgate rules to implement this section in accordance with the uniform administrative procedures act, compiled in title 4, chapter 5.

SECTION 18. This act shall take effect July 1, 2003, the public welfare requiring it.